Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be reimbursement for date of service 01/29/02.
   b. The request was received on 06/14/02.

II. EXHIBITS

1. Requestor, Exhibit I:
   a. TWCC-60
   b. HCFAs-1500
   c. EOBs/TWCC-62 forms
   d. Result of Spinal Surgery Second Opinion Process dated 08/01/01
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:
   a. TWCC-60
   b. HCFAs-1500
   c. EOBs/TWCC-62 forms
   d. Result of Spinal Surgery Second Opinion Process dated 08/01/01
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. The case file does not contain additional information from the provider as required by Rule 133.307 (g) (3). The additional information was requested from the provider by the Division on 07/11/02. Without the provider's additional information, the Division cannot comply with Rule 133.307 (g) (4). The response received from the carrier was received in the Division on 06/21/02 and is reflected in Exhibit II. All information in the medical dispute packet will be reviewed.

III. PARTIES' POSITIONS

1. Requestor: No Response

2. Respondent: No Response

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 01/29/02.

2. Per the provider's TWCC-60, the amount billed was $16,783.00; the amount paid was $0.00; the amount in dispute is $10,712.50.

3. The carrier denied the billed services by codes:
"1 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE OR USUAL AND CUSTOMARY ALLOWANCE. (Z560)";
"2 – THIS MULTIPLE PROCEDURE WAS REDUCED 50% ACCORDING TO FEE SCHEDULE OR USUAL AND CUSTOMARY GUIDELINES";
"*E – Entitlement (Non-Compensable)";
"(A) Pre-Authorization Not Obtained."

4. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MAR$	REFERENCE	RATIONALE:
01/29/02	63047-L4 63048-L5 22625-L5 22650-S1 22842 20975	$4,000.00 $2,600.00 $3,050.00 $650.00 $5,983.00 $500.00	$0.00 for all CPT codes	E,A,1 E,A,1 E,A,1,2 E,A,1 E,A,1 E,A,1	$3,540.00 $708.00 $2,529.00 $637.00 $3,400.00 $455.00	CPT descriptor; Rule 133.307 (g) (3); (A), (B), (C)	The provider failed to include any medical documentation to indicate that the service was rendered as billed. No reimbursement is recommended
Totals		$5,654.39	$0.00				The Requestor **is not** entitled to reimbursement.

The above Findings and Decision are hereby issued this 15th day of November 2002.

Donna M. Myers
Medical Dispute Resolution Officer
Medical Review Division

DMM/dmm